Initial Approval: January 13, 2016
Revised Dates: July 26, 2017

CRITERIA FOR PRIOR AUTHORIZATION

Antipsychotics in Children and Adolescents < 18 years of Age

PROVIDER GROUP Pharmacy

MANUAL GUIDELINES The following drug requires prior authorization:
Aripiprazole (Abilify®, Abilify Maintenna®, Aristada®)
Asenapine (Saphris®)
Brexpiprazole (Rexulti®)
Cariprazine (Vraylar®)
Chlorpromazine
Clozapine (Clozaril®, Fazaclo®)
Fluphenazine
Haloperidol (Haldol®)
Iloperidone (Fanapt®)
Loxapine (Adasuve®)
Lurasidone (Latuda®)
Olanzapine (Zyprexa®, Zyprexa Zydis®)
Olanzapine pamoate (Zyprexa Relprevv®)
Olanzapine/Fluoxetine (Symbyax®)
Paliperidone (Invega®)
Paliperidone palmitate (Invega Sustenna®, Invega Trinza®)
Perphenazine
Pimozide (Orap®)
Prochlorperazine maleate (Compazine®)
Quetiapine (Seroquel®)
Quetiapine fumarate (Seroquel XR®)
Risperidone (Risperdal®, Risperdal Consta®, Risperdal M-Tab®)
Thioridazine HCl
Thiothixene
Trifluoperazine
Ziprasidone (Geodon®)

CRITERIA FOR PRIOR AUTHORIZATION FOR ANTIPSYCHOTICS PRESCRIBED TO CHILDREN AGES < 4 YRS: (must meet all of the following)

- Must be prescribed only by a psychiatrist, neurologist, or developmental-behavioral pediatrician
- Must have a diagnosis of mood disorder, psychotic disorder, Tic disorder (i.e. Tourette's disorder), Autism Spectrum Disorder, PTSD with associated severe agitation.
- Documentation of attempted gathering of fasting plasma glucose, lipid screening, weight, height and Abnormal Involuntary Movement Scale (AIMS) evaluation within the previous 12 months.
- Attestation to Documentation of developmentally-appropriate, comprehensive psychiatric assessment in the child's medical record.
- Patient assessment to include DSM-5 or most updated edition of DSM diagnosis, screening for parental psychopathology, evaluation of family functioning and gathering collateral information from community resources (e.g.. School).
- Non-psychopharmacological interventions (i.e. training parents in evidence-based behavior management) have been initiated before (and maintained, if indicated, during) psychopharmacological treatment.
- The antipsychotic dose does not exceed the dosing limit listed on the attached table.
- Drugs listed on the table as not approved for the age range, requires an appeal.

LENGTH OF APPROVAL: 12 months

*A one-time 60 day override for this criteria requirement will be available to dispensing pharmacies through the Point-of-Sale PBM adjudication system.

PA Criteria

CRITERIA FOR PRIOR AUTHORIZATION FOR ANTIPSYCHOTICS PRESCRIBED TO CHILDREN AGES 4 YRS TO < 6 YRS: (must meet all of the following)

- Must be prescribed by or in consultation/collaboration with a psychiatrist, neurologist, or developmental-behavioral pediatrician.
- Must have a diagnosis of mood disorder, psychotic disorder, Tic disorder (i.e. Tourette's disorder), Autism Spectrum Disorder., PTSD with associated severe agitation.
- Documentation of attempted gathering of fasting plasma glucose, lipid screening, weight, height and Abnormal Involuntary Movement Scale (AIMS) evaluation within the previous 12 months.
- Attestation to Documentation of developmentally-appropriate, comprehensive psychiatric assessment in the child's medical record.
- Patient assessment to include DSM-5 or most updated recent edition of DSM diagnosis, screening for parental psychopathology, evaluation of family functioning and gathering collateral information from community resources (e.g. School).
- Non-psychopharmacological interventions (i.e. training parents in evidence-based behavior management) have been initiated before (and maintained, if indicated, during) psychopharmacological treatment.
- The antipsychotic dose does not exceed the dosing limit listed on the attached table.
- Drugs listed on the table as not approved for the age range, requires an appeal.

LENGTH OF APPROVAL: 12 months*

*A one-time 60 day override for this criteria requirement will be available to dispensing pharmacies through the Point-of-Sale PBM adjudication system.

CRITERIA FOR PRIOR AUTHORIZATION FOR ANTIPSYCHOTICS PRESCRIBED TO CHILDREN AGES 6 TO < 18YRS: (must meet all of the following)

- Must have a diagnosis of, Mood Disorder psychotic disorder,), Tic disorder (i.e. Tourette's disorder), Autism Spectrum Disorder, PTSD with associated severe agitation.
- Documentation of attempted gathering of fasting plasma glucose, lipid screening, weight, height and Abnormal Involuntary Movement Scale (AIMS) within the previous 12 months.
- Attestation to Documentation of developmentally-appropriate, comprehensive psychiatric assessment in the child's medical record, including DSM 5 or most updated edition of DSM diagnosis.
- Non-psychopharmacological interventions have been attempted and maintained when clinically indicated
- The antipsychotic dose does not exceed the dosing limit listed on the attached table.
- Drugs listed on the table as not approved for the age range, requires an appeal.

LENGTH OF APPROVAL: 12 months*

*A one-time 60 day override for this criteria requirement will be available to dispensing pharmacies through the Point-of-Sale PBM adjudication system.

RENEWAL CRITERIA:

- Documentation of attempted gathering of fasting plasma glucose, lipid screening, weight, height, and Abnormal Involuntary Movement Scale (AIMS) within the previous 12 months.

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

_____ _____

DATE DATE

PA Criteria
Table 1

Drug	Maximum Daily Dose* < 6yrs	Max Daily Dose* 6 To < 10yrs	Max Daily Dose* 10 To < 16yrs	Max Daily Dose* ≥ 16 To Adults
Aripiprazole (Abilify®, Abilify Discmelt®)	15mg	20mg	30mg	45mg
Aripiprazole (Abilify Maintenna®)	Not approved	Not approved	Not approved	400mg per 28 days
Aripiprazole lauroxil (Aristada®)	Not approved	Not approved	Not approved	882mg per 28 days
Asenapine (Saphris®)	Not approved	10mg	20mg	20mg
Brexpiprazole (Rexulti®)	Not approved	Not approved	Not approved	4mg
Cariprazine (Vraylar®)	Not approved	Not approved	Not approved	6mg
Chlorpromazine (oral)	40mg	200mg	800mg	1500mg
Clozapine (Clozaril®, Fazaclo®, Versacloz®)	Not approved	300mg	600mg	900mg
Fluphenazine (oral)	Not approved	5mg	10mg	60mg
Fluphenazine HCL and Decanoate (injection)	Not approved	Not approved	Not approved	100mg
Haloperidol (Haldol®)	6mg or 0.15mg/kg/day (“Lesser of”)	6mg	15mg	60mg
Haloperidol Decanoate (Haldol® Decanoate)	Not approved	Not approved	Not approved	500mg per 21 days
Iloperidone (Fanapt®)	Not approved	12mg	24mg	24mg
Loxapine (Adasuve®, Loxitane®)	Not approved	30mg	60mg	250mg
Lurasidone (Latuda®)	Not approved	80mg	120mg	160mg
Olanzapine (Zyprexa®, Zyprexa Zydis®)	Not approved	12.5mg	20mg	40mg
Olanzapine pamoate (Zyprexa Relprevv®)	Not approved	Not approved	Not approved	300mg per 14 days
Olanzapine/Fluoxetine (Symbyax®)	Not approved	Not approved	12mg/50mg	18mg/75mg
Paliperidone (Invega®)	Not approved	6mg	12mg	12mg
Paliperidone palmitate (Invega Sustenna®)	Not approved	Not approved	Not approved	234mg per 21 days
Paliperidone palmitate (Invega Trinza®)	Not approved	Not approved	Not approved	819mg per 84 days
Perphenazine	Not approved	12mg	22mg	64mg
Pimozide (Orap®)	Not approved	6mg or 0.2mg/kg/day (“Lesser of”)	10mg or 0.2mg/kg/day (“Lesser of”)	20mg
Quetiapine (Seroquel®, Seroquel XR®)	Not approved	400mg	800mg	1200mg
Risperidone (Risperdal®, Risperdal M-Tab®)	1.5mg	4mg	6mg	16mg
Risperidone (Risperdal Consta®)	Not approved	Not approved	Not approved	50mg per 14 days
Thioridazine	Not approved	Not approved	Not approved	800mg
Thiothixene	Not approved	Not approved	15mg	60mg
Trifluoperazine	Not approved	15mg	40mg	40mg
Ziprasidone (Geodon®)	Not approved	80mg	160mg	240mg

* Daily dose unless specified